



**BENEFIT CORRECTION REQUEST**  
State Form XXXXX (R/1-00)

State of Indiana  
State Personnel Department,  
Benefits Division

Agency:		Contact Person:	
Phone Number:		Email Address:	
Employee Name:	PeopleSoft ID:	SSN:	

Issue Involves:
<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical Spending Account <input type="checkbox"/> Dependent Care Spending Account
<input type="checkbox"/> Basic Life Insurance <input type="checkbox"/> Supplemental Life Insurance <input type="checkbox"/> Dependent Life Insurance

Description of Issue:
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Attach Supporting Documentation, for example: <ul style="list-style-type: none"><li>• Copy of most recent Benefit Statement or multiple statements if appropriate</li><li>• Copy of corresponding AS-47</li><li>• If applicable, copy of paper application on file</li><li>• If applicable, copy of student/disabled dependent certification</li></ul>
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SPD ONLY Note:
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Date Received:	Date Resolved:	Initials
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